



United Nations
Educational, Scientific and
Cultural Organization

Volume I The rationale for sexuality education

International Technical Guidance on Sexuality Education

An evidence-informed approach for schools,
teachers and health educators



UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
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WFP
UNFPA



**World Health
Organization**

Based on a rigorous and current review of evidence on sexuality education programmes, this *International Technical Guidance on Sexuality Education* is aimed at education and health sector decision-makers and professionals. It has been produced to assist education, health and other relevant authorities in the development and implementation of school-based sexuality education programmes and materials. *Volume I* focuses on the rationale for sexuality education and provides sound technical advice on characteristics of effective programmes. A companion document, (*Volume II*) focuses on the topics and learning objectives to be covered in a 'basic minimum package' on sexuality education for children and young people from 5 to 18+ years of age and includes a bibliography of useful resources. The *International Technical Guidance* is relevant not only to those countries most affected by HIV and AIDS, but also to those facing low prevalence and concentrated epidemics.

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December 2009

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Published by UNESCO

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Composed and printed by UNESCO
ED-2006/WS/36 REV2 (CLD 3528.9)

Foreword

Preparing children and young people for the transition to adulthood has always been one of humanity's great challenges, with human sexuality and relationships at its core. Today, in a world with AIDS, how we meet this challenge is our most important opportunity in breaking the trajectory of the epidemic.

In many societies attitudes and laws stifle public discussion of sexuality and sexual behaviour – for example in relation to contraception, abortion, and sexual diversity. More often than not, men's access to power is left unquestioned while girls, women and sexual minorities miss out.

Parents and families play a vital role in shaping the way we understand our sexual and social identities. Parents need to be able to address the physical and behavioural aspects of human sexuality with their children, and children need to be informed and equipped with the knowledge and skills to make responsible decisions about sexuality, relationships, HIV and other sexually transmitted infections.

Currently, far too few young people are receiving adequate preparation which leaves them vulnerable to coercion, abuse, exploitation, unintended pregnancy and sexually transmitted infections, including HIV. The UNAIDS 2008 Global Report on the AIDS Epidemic reported that only 40% of young people aged 15-24 had accurate knowledge about HIV and transmission. This knowledge is all the more urgent as young people aged 15-24 account for 45% of all new HIV infections.

We have a choice to make: leave children to find their own way through the clouds of partial information, misinformation and outright exploitation that they will find from media, the internet, peers and the unscrupulous, or instead face up to the challenge of providing clear, well informed, and scientifically-grounded sexuality education based in the universal values of respect and human rights. Comprehensive sexuality education can radically shift the trajectory of the epidemic, and young people are clear in their demand for more – and better – sexuality education, services and resources to meet their prevention needs.

If we are to make an impact on children and young people before they become sexually active, comprehensive sexuality education must become part of the formal school curriculum, delivered by well-trained and

supported teachers. Teachers remain trusted sources of knowledge and skills in all education systems and they are a highly valued resource in the education sector response to AIDS. As well, special efforts need to be made to reach children out of school – often the most vulnerable to misinformation and exploitation.

Based on a rigorous review of evidence on sexuality education programmes, this *International Technical Guidance on Sexuality Education* is aimed at education and health sector decision-makers and professionals. This document (*Volume I*) focuses on the rationale for sexuality education and provides sound technical advice on characteristics of effective programmes. A companion document (*Volume II*) focuses on the topics and learning objectives to be covered at different ages in basic sexuality education for children and young people from 5 to 18+ years of age, together with a bibliography of useful resources. The *International Technical Guidance* is relevant not only to those countries most affected by AIDS, but also to those facing low prevalence and concentrated epidemics.

This *International Technical Guidance on Sexuality Education* has been developed by UNESCO together with UNAIDS Cosponsors, particularly UNFPA, WHO and UNICEF as well as the UNAIDS Secretariat, as well as with a number of independent experts and those working in countries across the world to strengthen sexuality education. These efforts are a testament to the success of inter-agency collaboration and the priority which the UN attaches to our work with children and young people. This commitment is re-affirmed in the UNAIDS Outcome Framework 2009-2011, which identifies empowering young people to protect themselves from HIV as a key priority action area—among other things through the provision of rights-based sexual and reproductive health education.

In the response to AIDS, policy-makers have a special responsibility to lead, to take bold steps and to be prepared to challenge received wisdom when the world throws up new challenges. Nowhere is this more so than in the need to examine our beliefs about sexuality, relationships and what is appropriate to discuss with children and young people in a world affected by AIDS. I urge you to listen to young people, families, teachers and other practitioners, and to work with communities to overcome their concerns and use this *International Technical Guidance* to make sexuality education an integral part of the national response to the HIV pandemic.

Michel Sidibé
Executive Director, UNAIDS

Acknowledgements

This *International Technical Guidance on Sexuality Education* was commissioned by the United Nations Educational, Scientific and Cultural Organization (UNESCO). Its preparation, under the overall guidance of Mark Richmond, UNESCO Global Coordinator for HIV and AIDS, was organized by Chris Castle, Dhianaraj Chetty and Ekua Yankah in the Section on HIV and AIDS, Division for the Coordination of UN Priorities in Education at UNESCO.

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UNESCO would like to thank the William and Flora Hewlett Foundation for hosting the global technical consultation that contributed to the development of the guidance. The organizers would also like to express their gratitude to all of those who participated in the consultation, which took place from 18-19 February 2009 in Menlo Park, USA (in alphabetical order):

Prateek Awasthi, UNFPA; Arvin Bhana, Human Sciences Research Council (South Africa); Chris Castle, UNESCO; Dhianaraj Chetty, formerly ActionAid; Esther Corona, Mexican Association for Sex Education and World Association for Sexual Health; Mary Guinn Delaney, UNESCO; Nanette Ecker, SIECUS; Nike Esiet, Action Health, Inc. (AHI); Peter Gordon, independent consultant; Christopher Graham, Ministry of Education, Jamaica; Nicole Haberland, Population Council/USA; Sam Kalibala, Population Council/Kenya; Douglas Kirby, ETR Associates; Wenli Liu, Beijing Normal University; Elliot Marseille, Health Strategies International; Helen Omondi Mondoh, Egerton University; Prabha Nagaraja, Talking about Reproductive and Sexual Health Issues (TARSHI); Hans Olsson, The Swedish Association for Sexuality Education; Grace Osakue, Girls' Power Initiative (GPI) Nigeria; Jo Reinders, World Population Foundation (WPF); Sara Seims, the William and Flora Hewlett Foundation; and Ekua Yankah, UNESCO.

Written comments and contributions were also gratefully received from (in alphabetical order):

Peter Aggleton, Institute of Education at the University of London; Vicky Anning, independent consultant; Andrew Ball, World Health Organization (WHO); Prateek Awasthi, UNFPA; Tanya Baker, Youth Coalition for Sexual and Reproductive Rights; Michael Bartos, UNAIDS; Tania Boler, Marie Stopes International and formerly with UNESCO; Jeffrey Buchanan, formerly with UNESCO; Chris Castle, UNESCO; Katie Chau, Youth Coalition for Sexual and Reproductive Rights; Judith Cornell, UNESCO; Anton De Grauwe, UNESCO International Institute for Educational Planning (IIEP); Jan De Lind Van Wijngaarden, UNESCO; Marta Encinas-Martin, UNESCO; Jane Ferguson, WHO; Claudia Garcia-Moreno, WHO; Dakmara Georgescu, UNESCO International Bureau of Education (IBE); Cynthia Guttman, UNESCO; Anna Maria Hoffmann, United Nations Children's Fund (UNICEF); Roger Ingham, University of Southampton; Sarah Karmin, UNICEF; Eszter Kismodi, WHO; Els Klinkert, UNAIDS; Jimmy Kolker, UNICEF; Steve Kraus, UNFPA; Changu Mannathoko, UNICEF; Rafael Mazin, Pan American Health Organization (PAHO); Maria Eugenia Miranda, Youth Coalition for Sexual and Reproductive Rights; Jean O'Sullivan, UNESCO; Mary Otieno, UNFPA; Jenny Renju, Liverpool School of Tropical Medicine & National Institute for Medical Research; Mark Richmond, UNESCO; Pierre Robert, UNICEF; Justine Sass, UNESCO; Iqbal H. Shah, WHO; Shyam Thapa, WHO; Barbara Tournier, UNESCO IIEP; Friedl Van den Bossche, formerly UNESCO; Diane Widdus, UNICEF; Arne Willems, UNESCO; Ekua Yankah, UNESCO; and Barbara de Zalduondo, UNAIDS.

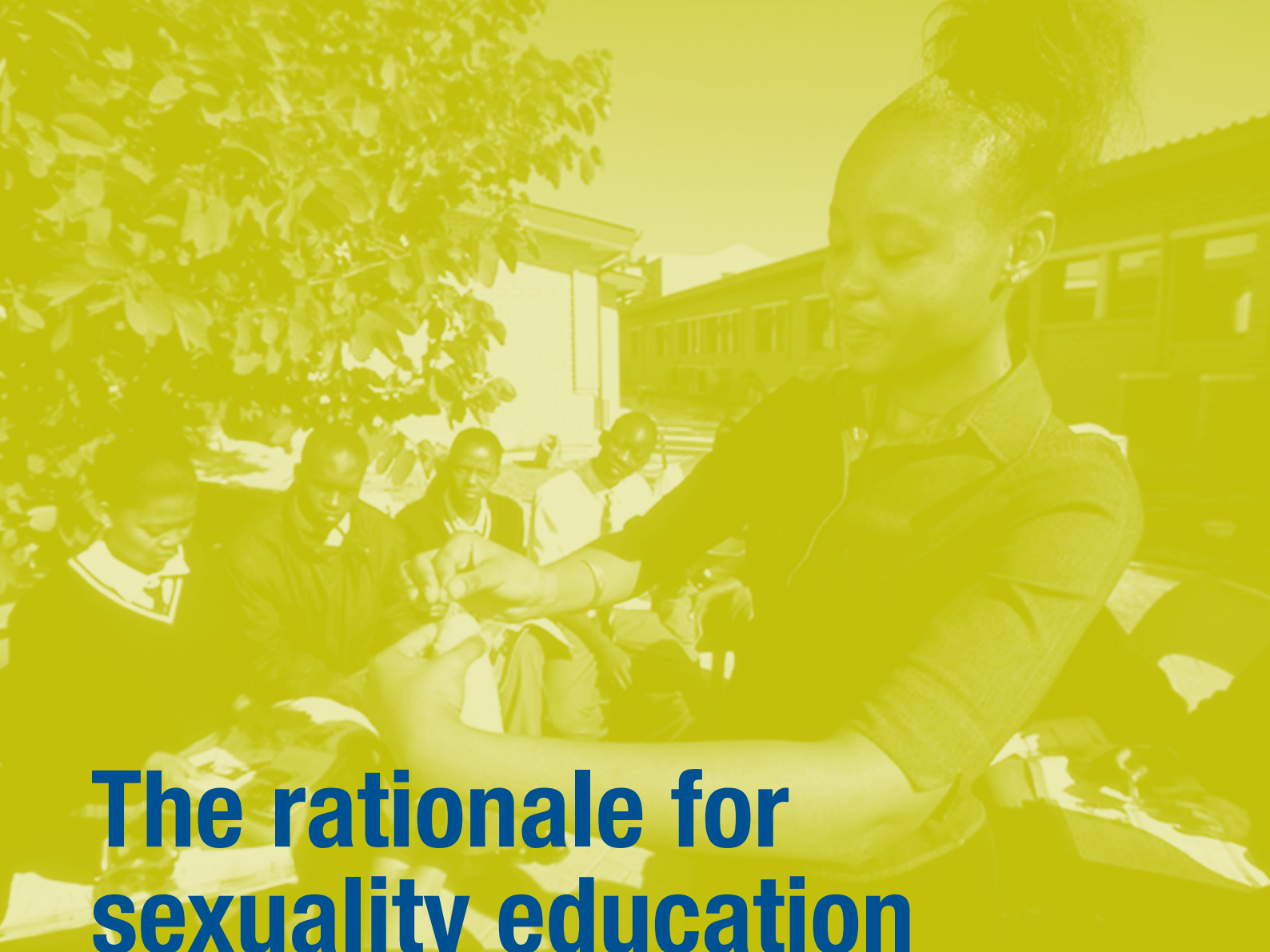
UNESCO would like to acknowledge Masimba Biriwasha, UNESCO; Sandrine Bonnet, UNESCO IBE; Claire Cazeneuve, UNESCO IBE; Claire Greslé-Favier, WHO; Magali Moreira, UNESCO IBE; and Lynne Sergeant, UNESCO IIEP for their contributions to the bibliography of resources. Finally, thanks are offered to Vicky Anning who provided editorial support, Aurélia Mazoyer and Myriam Bouarour who undertook the design and layout, and Schéhérazade Feddal who provided liaison support for the production of this document.

Acronyms

ASRH	Adolescent sexual and reproductive health
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Therapy
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
EFA	Education for All
ETR	Education, Training and Research
FHI	Family Health International
FWCW	Fourth World Conference on Women
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IATT	Inter-Agency Task Team
IBE	International Bureau of Education (UNESCO)
ICPD	International Conference on Population and Development
IIEP	International Institute for Educational Planning (UNESCO)
IPPF	International Planned Parenthood Federation
MDG	Millennium Development Goal
NGO	Non-Governmental Organization
PEP	Post-exposure prophylaxis
PFA	Platform for Action
POA	Programme of Action
SIECUS	Sexuality Information and Education Council of the United States
SRE	Sex and relationships education
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
STD	Sexually transmitted disease
STI	Sexually transmitted infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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The rationale for sexuality education

1. Introduction

1.1 What is sexuality education and why is it important?

This document is based upon the following assumptions:

- Sexuality is a fundamental aspect of human life: it has physical, psychological, spiritual, social, economic, political and cultural dimensions.
- Sexuality cannot be understood without reference to gender.
- Diversity is a fundamental characteristic of sexuality.
- The rules that govern sexual behaviour differ widely across and within cultures. Certain behaviours are seen as acceptable and desirable while others are considered unacceptable. This does not mean that these behaviours do not occur, or that they should be excluded from discussion within the context of sexuality education.

Few young people receive adequate preparation for their sexual lives. This leaves them potentially vulnerable to coercion, abuse and exploitation, unintended pregnancy and sexually transmitted infections (STIs), including HIV. Many young people approach adulthood faced with conflicting and confusing messages about sexuality and gender. This is often exacerbated by embarrassment, silence and disapproval of open discussion of sexual matters by adults, including parents and teachers, at the very time when it is most needed. There are many settings globally where young people are becoming sexually mature and active at an earlier age. They are also marrying later, thereby extending the period of time from sexual maturity until marriage.

Countries are increasingly signalling the importance of equipping young people with knowledge and skills to make responsible choices in their lives, particularly in a context where they have greater exposure to sexually explicit material through the Internet and other media. There is an urgent need to address the gap in knowledge about HIV among young people aged 15-24, with 60 per cent in this age range not able to correctly identify the ways of preventing HIV transmission (UNAIDS, 2008). A growing number of countries have implemented or are scaling up sexuality education¹ programmes, including

China, Kenya, Lebanon, Nigeria and Viet Nam, a trend confirmed by the ministers of education and health from countries in Latin America and the Caribbean at a summit held in August 2008. These efforts recognise that all young people need sexuality education, and that some are living with HIV or are more vulnerable to HIV infection than others, particularly adolescent girls married as children, those who are already sexually active, and those with disabilities.

Effective sexuality education can provide young people with age-appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to explore their attitudes and values, and to practise the decision-making and other life skills they will need to be able to make informed choices about their sexual lives.

Effective sexuality education is a vital part of HIV prevention and is also critical to achieving Universal Access targets for reproductive health and HIV prevention, treatment, care and support (UNAIDS, 2006). While it is not realistic to expect that an education programme alone can eliminate the risk of HIV and other STIs, unintended pregnancy, coercive or abusive sexual activity and exploitation, properly designed and implemented programmes can reduce some of these risks and underlying vulnerabilities.

Effective sexuality education is important because of the impact of cultural values and religious beliefs on all individuals, and especially on young people, in their understanding of this issue and in managing relationships with their parents, teachers, other adults and their communities.

Studies show (see section 4) that effective programmes can:

- reduce misinformation;
- increase correct knowledge;
- clarify and strengthen positive values and attitudes;

¹ Sexuality Education is defined as an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-

making, communication and risk reduction skills about many aspects of sexuality. The evidence review in section 4 of this document refers to this definition as the criterion for the inclusion of studies for the evidence review.

- increase skills to make informed decisions and act upon them;
- improve perceptions about peer groups and social norms; and
- increase communication with parents or other trusted adults.

Research shows that programmes sharing certain key characteristics can help to:

- abstain from or delay the debut of sexual relations;
- reduce the frequency of unprotected sexual activity;
- reduce the number of sexual partners; and
- increase the use of protection against unintended pregnancy and STIs during sexual intercourse.

School settings provide an important opportunity to reach large numbers of young people with sexuality education before they become sexually active, as well as offering an appropriate structure (i.e. the formal curriculum) within which to do so.

1.2 What are the goals of sexuality education?

The primary goal of sexuality education is that children and young people² become equipped with the knowledge, skills and values to make responsible choices about their sexual and social relationships in a world affected by HIV.

Sexuality education programmes usually have several mutually reinforcing objectives:

- to increase knowledge and understanding;
- to explain and clarify feelings, values and attitudes;
- to develop or strengthen skills; and
- to promote and sustain risk-reducing behaviour.

In a context where ignorance and misinformation can be life-threatening, sexuality education is part of the responsibility of education and health authorities and institutions. In its simplest interpretation, teachers in the classroom have a responsibility to act in partnership with parents and communities to ensure the protection and well-being of children and young people. At another level, the *International Technical Guidance* calls

for political and social leadership from education and health authorities to support parents by responding to the challenge of giving children and young people access to the knowledge and skills they need in their personal, social and sexual lives.

When it comes to sexuality education, programme designers, researchers and practitioners sometimes differ in the relative importance they attach to each objective and to the overall intended goal and focus. For educationalists, sexuality education tends to be part of a broader activity in which increasing knowledge (e.g. about prevention of unintended pregnancy and HIV) is valued both as a worthwhile outcome in its own right, as well as being a first step towards adopting safer behaviour. For public health professionals, the emphasis tends to prioritise reducing sexual risk behaviour.

1.3 What are the purpose and the intended audience of the International Technical Guidance?

This *International Technical Guidance* has been developed to assist education, health and other relevant authorities in the development and implementation of school-based sexuality education programmes and materials.

It will have immediate relevance for education ministers and their professional staff, including curriculum developers, school principals and teachers. However, anyone involved in the design, delivery and evaluation of sexuality education, in and out of school, may find this document useful. Emphasis is placed on the need for programmes that are locally adapted and logically designed to address and measure factors such as beliefs, values, attitudes and skills which, in turn, may affect sexual behaviour.

Sexuality education is the responsibility of the whole school via not only teaching but also school rules, in-school practices, the curriculum and teaching and learning materials. In a broader context, sexuality education is an essential part of a good curriculum and an essential part of a comprehensive response to AIDS at the national level.

² WHO/UNFPA/UNICEF (1999) define adolescence as the period of life between 10-19 years, and young people as those between 10-24 years. The United Nations Convention on the Rights of the Child (UN, 1989) considers children to be under the age of eighteen.

The *International Technical Guidance* is intended to:

- Promote an understanding of the need for sexuality education programmes by raising awareness of salient sexual and reproductive health issues and concerns affecting children and young people;
- Provide a clear understanding of what sexuality education comprises, what it is intended to do, and what the possible outcomes are;
- Provide guidance to education authorities on how to build support at community and school level for sexuality education;
- Build teacher preparedness and enhance institutional capacity to provide good quality sexuality education; and
- Provide guidance on how to develop responsive, culturally relevant and age-appropriate sexuality education materials and programmes.

This volume focuses on the ‘why’ and ‘what’ issues that require attention in strategies to introduce or strengthen sexuality education. Examples of ‘how’ these issues have been used in learning and teaching are presented in the list of resources, curricula and materials³ produced by many different organizations in the companion document on topics and learning objectives (<http://www.unesco.org/aids>).

1.4 How is the International Technical Guidance structured?

The *International Technical Guidance on Sexuality Education* comprises two volumes. First, Volume I (this document) is focused on the rationale for sexuality education. Second, Volume II (a companion volume) presents key concepts and topics, together with learning objectives and key ideas for four distinct age groups. These features represent a set of global benchmarks that can and should be adapted to local contexts to ensure relevance, to provide ideas for how to monitor the content of what is being taught and to assess progress towards the achievement of teaching and learning objectives.

³ The resource materials contained in Appendix V Volume II were identified by participants at the global technical consultation in February 2009, and do not carry an endorsement by the UN agencies who produced this *International Technical Guidance*.

As a package, the *International Technical Guidance* provides a platform for those involved in policy, advocacy and the development of new programmes or the review and scaling up of existing programmes.

1.5 How was the International Technical Guidance developed?

The development of the rationale (Volume I) was informed by a specially commissioned review of the literature on the impact of sexuality education on sexual behaviour. The review considered 87 studies from around the world; 29 studies were from developing countries, 47 from the United States and 11 from other developed countries. The common characteristics of existing and evaluated sexuality education programmes were identified and verified through independent review, based on their effectiveness in increasing knowledge, clarifying values and attitudes, developing skills and at times impacting upon behaviour.

The Guidance was further developed through a global technical consultation meeting held in February 2009 with experts from 13 countries (see list in Appendix IV). Colleagues from UNAIDS, UNESCO, UNFPA, UNICEF and WHO have also provided input into this document.

The Guidance was developed through a process designed to ensure high quality, acceptability and ownership at the international level. At the same time, it should be noted that the Guidance is voluntary and non-binding in character and does not have the force of an international normative instrument.

The application of the *International Technical Guidance* must be fully consistent with national laws and policies, and take into account local and community values and norms. Even for an average school setting this is important; teachers and school managers are called upon to exercise particular care in carrying out their duties in areas of the curriculum which parents and communities consider to be sensitive. It is hoped that the Guidance constructively contributes to this effort.

2. Background

2.1 Young people's sexual and reproductive health

Sexual and reproductive ill-health is a major contribution to the burden of disease among young people. Ensuring the sexual and reproductive health of young people makes social and economic sense: HIV infection, other STIs, unintended pregnancy and unsafe abortion all place substantial burdens on families and communities and upon scarce government resources, and yet such burdens are preventable and reducible. Promoting young people's sexual and reproductive health, including the provision of sexuality education in schools, is thus a key strategy towards achieving the Millennium Development Goals (MDGs), especially MDG 3 (achieving gender equality and empowerment of women), MDG 5 (reducing maternal mortality and achieving universal access to reproductive health) and MDG 6 (combating HIV/AIDS).

The sexual development of a person is a process that comprises physical, psychological, emotional, social and cultural dimensions⁴. It is also inextricably linked to the development of one's identity and it unfolds within specific socio-economic and cultural contexts. The transmission of cultural values from one generation to the next forms a critical part of socialisation; it includes values related to gender and sexuality. In many communities, young people are exposed to several sources of information and values (e.g. from parents, teachers, media and peers). These often present them with alternative or even conflicting values about gender, gender equality and sexuality. Furthermore, parents are often reluctant to engage in discussion of sexual matters with children because of cultural norms, their own ignorance or discomfort.

According to the World Health Organization (WHO, 2002), in many cultures puberty represents a time of social as well as physical change for both boys and girls. For boys, puberty can be a gateway to increased freedom, mobility and social opportunities. This may also be the case for girls, but in other instances puberty for



girls may signal an end to schooling and mobility, and the beginning of adult life, with marriage and childbearing as expected possibilities in the near future.

'Being sexual' is an important part of many people's lives: it can be a source of pleasure and comfort and a way of expressing affection and love or starting a family. It can also involve negative health and social outcomes. Whether or not young people choose to be sexually active, sexuality education prioritises the acquisition and/or reinforcement of values such as reciprocity, equality, responsibility and respect, which are prerequisites for healthy and safer sexual and social relationships. Unfortunately, not all sexual relations are consensual, and can be forced including rape.

The past four decades have seen dramatic changes in our understanding of human sexuality and sexual behaviour (WHO, 2002). The global HIV epidemic has played a role in bringing about this change, because it was rapidly understood that, in order to address HIV – which is largely sexually transmitted – we needed to acquire a better understanding of gender and sexuality. According to the Joint United Nations Programme on HIV/AIDS and the World Health Organization (UNAIDS/WHO unpublished estimates, 2008), more than 5.5 million young people globally are living with HIV, two-thirds of whom live in sub-Saharan Africa. Roughly 45 per cent of all new infections occur in the 15 to 24 age group (UNAIDS, 2008). Globally, women constitute 50 per cent of the total number of people living with HIV, but in sub-Saharan Africa, this proportion rises to approximately 60 per cent (UNAIDS, 2008; Stirling *et al.*, 2008).

In many countries, it appears that young people with HIV are living longer, thanks to improved access to treatment with anti-retroviral therapy (ART) and related medical and psychosocial support. Young people living with HIV, including those infected perinatally,

⁴ This definition of human sexual development is derived from *Sexual Health: Report of a technical consultation on sexual health*, WHO, 2002.

have particular needs in relation to their sexual and reproductive health (WHO and UNICEF, 2008). These needs include: opportunities to discuss living positively with HIV; sexuality and relationships; and issues relating to disclosure, stigma and discrimination. However, these needs are often unmet. For example, experience in one country in East Africa (Birungi, Mugisha, and Nyombi, 2007) reveals that young people living with HIV are often discriminated against by sexual and reproductive health providers and are actively discouraged from engaging in sexual activity. Sixty per cent of those living with HIV reported that they had not disclosed their status to their sexual partners; 39 per cent were in relationships with a sexual partner who did not have HIV. Many did not know how to disclose their status to their partners.

Knowledge about HIV transmission remains low in many countries, with women generally less well informed than men. According to UNAIDS (UNAIDS, 2008), many young people still lack accurate, complete information on how to avoid exposure to HIV. While UNAIDS reports that more than 70 per cent of young men know that condoms can protect against HIV, only 55 per cent of young women cite condoms as an effective strategy for HIV prevention. Survey data from sixty-four countries indicate that only 40 per cent of males and 38 per cent of females aged 15 to 24 had accurate and comprehensive knowledge about HIV and its prevention (UNAIDS, 2008). This figure falls well short of the global goal of 'ensuring comprehensive HIV knowledge in 95 per cent of young people by 2010' (UN, 2001). UNAIDS (UNAIDS and WHO, 2007) reported that at least half of students around the world did not receive any school-based HIV education. Furthermore, five out of fifteen countries reporting to UNAIDS in 2006 indicated that the coverage of HIV prevention in schools was less than 15 per cent.

Globally, young people continue to have high rates of STIs. According to the International Planned Parenthood Federation, at least 111 million new cases of curable STIs occur each year among young people aged 10 to 24 (IPPF, 2006). WHO estimates that up to 2.5 million girls aged 15 to 19 years old in developing countries have abortions, the majority of which are unsafe (WHO, 2007). Eleven per cent of births worldwide are to adolescent mothers, who experience higher rates of maternal mortality than older women (WHO, 2008a).

2.2 The role of schools

The education sector has a critical role to play in preparing children and young people for their adult roles and responsibilities (Delors *et al.*, 1996); the transition to adulthood requires becoming informed and equipped with the appropriate knowledge and skills to make responsible choices in their social and sexual lives. Moreover, in many countries, young people have their first sexual experiences while they are still attending school, making the setting even more important as an opportunity to provide education about sexual and reproductive health.

In most countries, children between the ages of five and thirteen, in particular, spend relatively large amounts of time in school. Thus, schools provide a practical means of reaching large numbers of young people from diverse backgrounds in ways that are replicable and sustainable (Gordon, 2008). School systems benefit from an existing infrastructure, including teachers likely to be a skilled and trusted source of information, and long-term programming opportunities through formal curricula. School authorities have the power to regulate many aspects of the learning environment to make it protective and supportive, and schools can also act as social support centres, trusted institutions that can link children, parents, families and communities with other services (for example, health services). However, schools can only be effective if they can ensure the protection and well-being of their learners and staff, if they provide relevant learning and teaching interventions, and if they link up to psychosocial, social and health services. Evidence from UNESCO, WHO, UNICEF and the World Bank (WHO and UNICEF, 2003) point to a core set of cost-effective legislative, structural, behavioural and biomedical measures that can contribute to making schools healthy for children.

Age-appropriate sexuality education is important for all children and young people, in and out of school. While the *International Technical Guidance* focuses specifically upon the school setting, much of the content will be equally relevant to those children who are out of school.

2.3 Young people's need for sexuality education

The *International Technical Guidance* is predicated on the view that children and young people have a specific need for the information and skills provided through sexuality education that makes a difference to their life chances⁵. The threat to life and their well-being exists in a range of contexts, whether it is in the form of abusive relationships, health risks associated with early unintended pregnancy, exposure to STIs including HIV or stigma and discrimination because of their sexual orientation. Given the complexity of the task facing any teacher or parent in guiding and supporting the process of learning and growth, it is crucial to strike the right balance between the need to know and what is age-appropriate and relevant.

Box 1. Sexual activity has consequences: examples from Uganda

It is important to recognise that sexual intercourse has consequences that go beyond unintended pregnancy or exposure to STIs including HIV, as illustrated in the case of Uganda:

'Ugandan boys and girls who have sex early are twice as likely not to complete secondary school as adolescents who have never had sex.' For many reasons, 'currently only 10% of boys and 8% of girls complete secondary school in Uganda' (Demographic and Health Survey Uganda, 2006).

In Uganda, thousands of boys are in jail for consensual sex with girls aged less than 18 years. Parents of many more have had to sell land and livestock to keep their sons out of jail.

Pregnancy for a 17 year old Ugandan girl may mean that she has to leave school forever or marry a man with other wives (17% are in polygamous unions). About 50% of adolescent girls in Uganda give birth attended only by a relative or traditional birth attendant or alone.

Source: Straight Talk Foundation Annual Report 2008 available on <http://www.straight-talk.org.ug>

2.4 Addressing sensitive issues

The challenge for sexuality education is to reach young people before they become sexually active, whether this is through choice, necessity (e.g. in exchange for money, food or shelter), coercion or exploitation. For many developing countries, this discussion will require attention to other aspects of vulnerability, particularly disability and socio-economic factors. Furthermore, some students, now or in the future, will be sexually active with members of their own sex. These are sensitive and challenging issues for those with responsibility for designing and delivering sexuality education, and the needs of those most vulnerable must be taken into particular consideration.

The *International Technical Guidance* emphasises the importance of addressing the *reality* of young people's sexual lives: this includes some aspects which may be controversial or difficult to discuss in some communities. Ideally, rigorous scientific evidence and public health imperatives should take priority.



5 International human rights standards recognise that adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health, including sexual and reproductive health. (Convention on the Rights of the Child General Comment 4(2003) para. 26 & Committee on Economic Social and Cultural Rights General Comment 14(2000) para. 11)

3. Building support and planning for the implementation of sexuality education

Despite the clear and pressing need for effective school-based sexuality education, in most countries throughout the world this is still not available. There are many reasons for this, including ‘perceived’ or ‘anticipated’ resistance resulting from misunderstandings about the nature, purpose and effects of sexuality education. Evidence suggests that many people, including education ministry staff, school principals and teachers, may not be convinced of the need to provide sexuality education, or else are reluctant to provide it because they lack the confidence and skills to do so. Teachers’ personal or professional values could also be in conflict with the issues they are being asked to address, or else there is no clear guidance about what to teach and how to teach it (see Table 1 for some examples of common concerns that are expressed about introducing or promoting sexuality education).

Table 1. Common concerns about the provision of sexuality education

Concerns	Response
Sexuality education leads to early sex.	Research from around the world clearly indicates that sexuality education rarely, if ever, leads to early sexual initiation. Sexuality education can lead to later and more responsible sexual behaviour or may have no discernible impact on sexual behaviour.
Sexuality education deprives children of their ‘innocence’.	Getting the right information that is scientifically accurate, non-judgemental, age-appropriate and complete in a carefully phased process from the beginning of formal schooling is something from which all children and young people benefit. In the absence of this, children and young people will often receive conflicting and sometimes damaging messages from their peers, the media or other sources. Good quality sexuality education balances this through the provision of correct information and an emphasis on values and relationships.
Sexuality education is against our culture or religion.	The <i>International Technical Guidance</i> stresses the need for cultural relevance and local adaptations, through engaging and building support among the custodians of culture in a given community. Key stakeholders, including religious leaders, must be involved in the development of what form sexuality education takes. However, the guidance also stresses the need to change social norms and harmful practices that are not in line with human rights and increase vulnerability and risk, especially for girls and young women.
It is the role of parents and the extended family to educate our young people about sexuality.	Traditional mechanisms for preparing young people for sexual life and relationships are breaking down in some places, often with nothing to fill the void. Sexuality education recognises the primary role of parents and the family as a source of information, support and care in shaping a healthy approach to sexuality and relationships. The role of governments through ministries of education, schools and teachers, is to support and complement the role of parents by providing a safe and supportive learning environment and the tools and materials to deliver good quality sexuality education.
Parents will object to sexuality education being taught in schools.	Parents and families play a primary role in shaping key aspects of their children's sexual identity, and sexual and social relationships. Schools and educational institutions where children and young people spend a large part of their lives are an appropriate environment for young people to learn about sex, relationships and HIV and other STIs. When these institutions function well, young people are able to develop the values, skills and knowledge to make informed and responsible choices in their social and sexual lives. Teachers should be qualified and trusted providers of information and support for most children and young people. In most cases, parents are among the strongest supporters of quality sexuality education programmes in schools.
Sexuality education may be good for young people, but not for young children.	The <i>International Technical Guidance</i> is built upon the principle of age-appropriateness reflected in the grouping of learning objectives, outlined in Volume II, with flexibility to take account of local and community contexts. Sexuality education encompasses a range of relationships, not only sexual relationships. Children are aware of and recognise these relationships long before they act on their sexuality and therefore need the skills to understand their bodies, relationships and feelings from an early age. Sexuality education lays the foundations e.g. by learning the correct names for parts of the body, understanding principles of human reproduction, exploring family and interpersonal relationships, learning about safety, and developing confidence. These can then be built upon gradually, in line with the age and development of a child.

<p>Teachers may be willing to teach sexuality education but are uncomfortable, lacking in skills or afraid to do so.</p>	<p>Well-trained, supported and motivated teachers play a key role in the delivery of good quality sexuality education. Clear sectoral and school policies and curricula help to support teachers in this regard. Teachers should be encouraged to specialise in sexuality education through added emphasis on formalising the subject in the curriculum, as well as stronger professional development and support.</p>
<p>Sexuality education is already covered in other subjects (biology, life skills or civics education).</p>	<p>Ministries, schools and teachers in many countries are already responding to the challenge of improving sexuality education. Whilst recognising the value of these efforts, using the <i>International Technical Guidance</i> presents an opportunity to evaluate and strengthen the curriculum, teaching practice and the evidence base in a dynamic and rapidly changing field.</p>
<p>Sexuality education should promote values.</p>	<p>The <i>International Technical Guidance</i> on Sexuality Education supports a rights-based approach in which values such as respect, acceptance, tolerance, equality, empathy and reciprocity are inextricably linked to universally agreed human rights. It is not possible to divorce considerations of values from discussions of sexuality.</p>

3.1 Key stakeholders

Sexuality education attracts both opposition and support. Should opposition occur, it is by no means insurmountable. Ministries of education play a critical role in building consensus on the need for sexuality education through consultation and advocacy with key stakeholders, including, for example:

- Young people represented by their diversity and organizations that work with them;
- Parents and parent-teacher associations;
- Policy-makers and politicians;
- Government ministries, including health and others concerned with the needs of young people;
- Educational professionals and institutions including teachers, head teachers and training institutions;
- Religious leaders and faith-based organizations;
- Teachers' trade unions;
- Training institutions for health professions;
- Researchers;
- Community and traditional leaders;
- Lesbian, gay, bisexual and transgender groups;
- NGOs, particularly those working on sexual and reproductive health with young people;
- People living with HIV;
- Media (local and national); and
- Relevant donors or outside funders.

Studies and practical experience have shown that sexuality education programmes can be more attractive to young people and more effective if young people play a role in developing the curriculum. Facilitating dialogue between different stakeholders, especially between

young people and adults, could be considered as one of the strategies to build support. There are multiple roles that young people can play. For example, they can identify some of their particular concerns and commonly held beliefs about sexuality, suggest activities that address such concerns, help make role-play scenarios more realistic, and suggest refinements in all activities during pilot-testing (Kirby, 2009).

Box 2. Involving Young People

A report published in 2007 by the UK Youth Parliament, based on questionnaire responses from over 20,000 young people, says that 40 per cent of young people described the sex and relationships education (SRE) they had received as either 'poor' or 'very poor', with a further 33 per cent describing it as only average. Other key findings from the survey were that:

- 43 per cent of respondents reported not having been taught anything about relationships;
- 55 per cent of the 12-15 year olds and 57 per cent of the 16-17 year old females reported not having been taught how to use a condom;
- Just over half of respondents had not been told where their local sexual health service was located.

Involving a structure like the Youth Parliament in the process of reviewing SRE provision yielded important data. The report also illustrates the scale of the challenge in meeting young people's needs, even in developed countries' education systems. Partly because young people got involved in the UK Youth Parliament process, compulsory sex and relationships education was announced in England in 2008.

Source: Fisher, J. and McTaggart J. *Review of Sex and Relationships Education (SRE) in Schools*, Issues 2008, Chapter 3, Section 14. www.teachernet.gov.uk/_doc/13030/SRE%20final.pdf or <http://ukyouthparliament.org.uk/sre>

3.2 Developing the case for sexuality education

A clear rationale for the introduction of sexuality education can be developed on the basis of evidence from the local/national situation and needs assessments. This should include local data on HIV, other STIs and teenage pregnancy, sexual behaviour patterns of young people, including those thought to be most vulnerable, together with studies on specific factors associated with HIV and other STI risk and vulnerability. Ideally, this will include both quantitative and qualitative information; sex and gender-specific data regarding the age and experience of sexual initiation; partnership dynamics, including the number of sexual partners and age differences; rape, coercion or exploitation; duration and concurrency of partnerships; use of condoms and contraception; and use of available health services.

Box 3. Latin America and the Caribbean: Leading the call to action

A growing number of governments around the world are confirming their commitment to sexuality education as a priority essential to achieving national development, health and education goals. In August 2008, health and education ministers from across Latin America and the Caribbean came together in Mexico City to sign a historic declaration affirming a mandate for national school-based sexuality and HIV education throughout the region. The declaration advocates for strengthening comprehensive sexuality education and for making it a core area of instruction in both primary and secondary schools in the region.

Main features of the Ministerial Declaration include:

- A call to implement and/or strengthen multisectoral strategies for comprehensive sexuality education and the promotion and care of sexual health, including HIV prevention;
- An understanding that comprehensive sexuality education entails human rights, ethical, biological, emotional, social, cultural and gender aspects; respects diversity of sexual orientations and identities.

See also: http://www.unaids.org/en/KnowledgeCentre/Resources/FeatureStories/archive/2008/20080731_Leaders_Ministerial.asp

http://data.unaids.org/pub/BaseDocument/2008/20080801_ministerdeclaration_en.pdf

http://data.unaids.org/pub/BaseDocument/2008/20080801_ministerdeclaration_es.pdf

3.3 Planning for implementation

In some countries, National Advisory Councils and/or Task Force Committees have been established by ministries of education to inform the development of relevant policies, to generate support for programmes, and to assist in the development and implementation of sexuality education programmes. Council and committee members tend to include national experts and practitioners in sexual and reproductive health, human rights, education, gender equality, youth development and education and may also include young people. Individually and collectively, council and committee members are often able to participate in sensitisation and advocacy, review draft materials and policies, and develop a comprehensive workplan for classroom delivery together with plans for monitoring and evaluation. At the policy level, a well-developed national policy on sexuality education may be explicitly linked to education sector plans, as well as to the national strategic plan and policy framework on HIV.

To ensure continuity and consistency and to encourage constructive engagement with efforts to improve sexuality education, discussions about building support and capacity for school-based sexuality education may occur at, and across, all levels. Participants in such discussions can be provided, as appropriate, with orientation and training in sexuality and sexual and reproductive health. This can include values clarification and skills training to overcome embarrassment in addressing sexuality. Teachers responsible for the delivery of sexuality education will usually also need training in the specific skills needed to address sexuality clearly, as well as the use of active, participatory learning methods.

3.4 At school level

The overall school context within which sexuality education is to be delivered is crucially important. In this regard, two linked factors will make a difference: (1) leadership, and (2) policy guidance. Firstly, school management is expected to take the lead in motivating and supporting, as well as creating the right climate in which to implement sexuality education and address the needs of young people. From the perspective of a classroom, instructional leadership calls on teachers to lead children and young people towards a better

understanding of sexuality through discovery, learning and growth. In a climate of uncertainty or conflict, the capacity to lead amongst managers and teachers can make the difference between successful programmatic interventions and those that falter.

Secondly, the sensitive and sometimes controversial nature of sexuality education makes it important that supportive and inclusive laws and policies are in place, demonstrating that the provision of sexuality education is a matter of institutional policy rather than the personal choice of individuals. Implementing sexuality education within a clear set of relevant school-wide policies or guidelines concerning, for example, sexual and reproductive health, gender equality (including sexual harassment), sexual and gender-based violence, and bullying (including stigma and discrimination on the grounds of sexual orientation and gender identity) has a number of advantages. A policy framework will:

- Provide an institutional basis for the implementation of sexuality education programmes;
- Anticipate and address sensitivities concerning the implementation of sexuality education programmes;
- Set standards on confidentiality;
- Set standards of appropriate behaviour; and
- Protect and support teachers responsible for delivery of sexuality education and, if appropriate, protect or increase their status within the school and community.

It is possible that some of these issues may be well defined through pre-existing school policies. For example, most school-based policies on HIV pay specific attention to issues of confidentiality, discrimination and gender equality. However, in the absence of pre-existing guidance, a policy on sexuality education will clarify and strengthen the school's commitment to:

- Curriculum delivery by trained teachers;
- Parental involvement;
- Procedures for responding to parental concerns;
- Supporting pregnant learners to continue with their education;
- Making the school a health-promoting environment (through the provision of clean, private, separate toilets for girls and boys, and other measures);
- Action in the case of infringement of policy, for example, in the case of breach of confidentiality, stigma and discrimination, sexual harassment or bullying; and
- Promoting access and links to local sexual and reproductive health and other services in accordance with national laws.

Decisions will also need to be made about how to select teachers to implement sexuality education programmes, and whether this should be done by aptitude or personal preference, or whether it should be required of all teachers delivering a particular subject or set of subjects.

Implementation planning normally would take into consideration the adequate development and provision of resources (including materials), and reaching agreement on the place of the programme within the broader curriculum. Furthermore, it would typically include planning for pre-service training at teacher training institutions and in-service and refresher training for classroom teachers, to build their comfort and confidence, and to develop their skills in participatory and active learning (Kirby, 2009).

For students to feel comfortable participating in sexuality education group activities, they need to feel safe. It is therefore essential to create a protective and enabling environment for sexuality education. This usually includes the establishment, at the outset, of a set of ground rules to be followed during teaching and learning of sexuality education. Typical examples include: avoidance of ridicule and humiliating comments; not asking personal questions; respecting the right not to answer questions; recognising that all questions are legitimate; not interrupting; respecting the opinions of others; and maintaining confidentiality. Research has shown that some curricula also encourage positive reinforcement of student participation. Separating students into same-sex groups, for part or all of a programme, has also been demonstrated to be effective (Kirby, 2009).

Safety in the classroom environment should be reinforced by anti-homophobic and anti-gender discrimination policies that are consistent with the curriculum. More generally, the ethos of the school should be aligned with the values and goals of the curriculum. Schools need to be 'safe places' where learners can express themselves without concern about being humiliated, rejected or mistreated and where there is zero tolerance for relationships between students and teachers (Kirby, 2009).

3.5 Parental involvement

Some parents may have strong views and concerns about the effects of sexuality education. Sometimes, these concerns are based on limited information or misapprehensions about the nature and effects of sexuality education, or perceptions of norms in society. The cooperation and support of parents, families and other community actors should be sought from the outset and regularly reinforced as young people's perceptions and behaviours are greatly influenced by family and community values, social norms and conditions. It is important to emphasise the shared primary concern of schools and parents with promoting the safety and well-being of children and young people.

Parental concerns can be addressed through the provision of parallel programmes that orient them to the content of their children's learning and that equip them with skills to communicate more openly and honestly about sexuality with their children, putting their fears to rest and supporting the school's efforts in delivering good quality sexuality education. Research has shown that one of the most effective ways to increase parent-to-child communication about sexuality is to provide student homework assignments to discuss selected topics with parents or other trusted adults (Kirby, 2009). If teachers and parents support each other in implementing a guided and structured teaching/learning process, the chances of personal growth for children and young people are likely to be much better.



3.6 Schools as community resources

Schools can become trusted community centres that provide necessary links to other resources, such as services for sexual and reproductive health, substance abuse, gender-based violence and domestic crisis (UNESCO, 2008b). This link between the school and community is particularly important in terms of child protection, since some groups of children and young people are particularly vulnerable. These include those who are married, displaced, disabled, orphaned, or living with HIV. They need relevant information and skills to protect themselves, together with access to community services to help protect them from violence, exploitation and abuse.

4. The evidence base for sexuality education

4.1 2008 Review of the impact of sexuality education on sexual behaviour

This section summarises the findings of a recent review of the impact of sexuality education on sexual behaviour. It was commissioned by UNESCO during 2008-2009 as part of the development of the *International Technical Guidance*. In order to identify as many of the studies as possible throughout the world, the review team searched multiple computerised databases, examined results from previous searches, contacted 32 researchers in this field, attended professional meetings where relevant studies might be presented, and scanned each issue of 12 journals. (Please refer to Appendix II for a detailed description of the criteria for the selection of evaluation studies and for additional information about the methods used to identify studies.)

Table 2. The number of sexuality education programmes demonstrating effects on sexual behaviours

	Developing Countries (N=29)	United States (N=47)	Other developed Countries (N=11)	All Countries (N=87)	
Initiation of Sex					
• Delayed initiation	6	15	2	23	37%
• Had no significant impact	16	17	7	40	63%
• Hastened initiation	0	0	0	0	0%
Frequency of Sex					
• Decreased frequency	4	6	0	10	31%
• Had no significant impact	5	15	1	21	66%
• Increased frequency	0	0	1	1	3%
Number of Sexual Partners					
• Decreased number	5	11	0	16	44%
• Had no significant impact	8	12	0	20	56%
• Increased number	0	0	0	0	0%
Use of Condoms					
• Increased use	7	14	2	23	40%
• Had no significant impact	14	17	4	35	60%
• Decreased use	0	0	0	0	0%
Use of Contraception					
• Increased use	1	4	1	6	40%
• Had no significant impact	3	4	1	8	53%
• Decreased use	0	1	0	1	7%
Sexual Risk-Taking					
• Reduced risk	1	15	0	16	53%
• Had no significant impact	3	9	1	13	43%
• Increased risk	1	0	0	1	3%

The review found 87 studies⁶ from around the world (see Table 2) meeting the criteria; 29 studies were from developing countries, 47 from the United States and 11 from other developed countries. All of the programmes were designed to reduce unintended pregnancy or STIs, including HIV; they were not designed to address the varied needs of young people or their right to information about many topics. All were curriculum-based programmes, 70 per cent were implemented in schools and the remainder were implemented in community or clinic settings. Many of the programmes were very modest, lasting less than 30 hours or even 15 hours. The review examined the impact of these programmes on those sexual behaviours that directly affect pregnancy and sexual transmission of HIV and other STIs. It did not review impact on other behaviours such as health-seeking behaviour, sexual harassment, sexual violence or unsafe abortion.

Limitations and strengths of the review

There were a number of limitations to the studies and, by implication, to the review. Too few of the studies were conducted in developing countries. Some studies suffered from an inadequate description of their respective programmes. None examined programmes for gay or lesbian or other young people engaging in same-sex sexual behaviour. Some studies had only barely adequate evaluation designs and many were statistically underpowered. Most did not adjust for multiple tests of significance. Few studies measured impact upon either STI or pregnancy rates and fewer still measured impact on STI or pregnancy rates with biological markers. Finally, there were inherent biases that affect the publication of studies: researchers are more likely to try to publish articles if positive results support their theories. Also, programmes and journals are more likely to accept articles for publication when the results are positive.

Despite these limitations, there is much to be learned from these studies for several reasons: 1) 87 studies, all with experimental or quasi-experimental designs, is a large number of studies; 2) some of the studies employed strong research designs and their results were similar to those with weaker evaluation designs; 3) when the same programmes were studied multiple times, often the same or similar results were obtained; and 4) the programmes that were effective at changing sexual behaviour often shared common characteristics.

6 These studies evaluated 85 programmes (some programmes had multiple articles).

4.2 Impact on sexual behaviour

Of 63 studies⁷ that measured the impact of sexuality education programmes upon the initiation of sexual intercourse, 37 per cent of programmes delayed the initiation of sexual intercourse among either the entire sample or an important sub-sample, while 63 per cent had no impact. Notably, none of the programmes hastened the initiation of sexual intercourse. Similarly, 31 per cent of the programmes led to a decrease in the frequency of sexual intercourse (which includes reverting to abstinence), while 66 per cent had no impact and 3 per cent increased the frequency of sexual intercourse. Finally, 44 per cent of the programmes decreased the number of sexual partners, 56 per cent had no impact in this regard, and none led to an increased number of partners. The small percentages of results in the undesired direction are equal to, or less than, that which would be expected by chance, given the large number of tests of significance that were examined. Also by the same principle, a few of the positive results were probably the result of chance.

Taken together, these studies provide some evidence that programmes that emphasise not having sexual intercourse as the safest option and that also discuss condom and contraceptive use do not increase sexual behaviour. On the contrary:

- more than a third of programmes delayed the initiation of sexual intercourse;
- about a third of programmes decreased the frequency of sexual intercourse; and
- more than a third of programmes decreased the number of sexual partners, either among the entire sample or in important sub-samples.

In addition to the effects of the sexuality education programmes described above, 11 abstinence programmes, all of which were conducted in the United States⁸, were reviewed. These 11 studies did not meet the selection criteria of the review and were thus analysed separately. Two of the 11 studies reported that the evaluated programmes delayed sexual initiation, while nine revealed no impact. Two out of eight studies found the programme reduced the frequency of sex, while six programmes had no impact. Finally, one out

7 More than half of the 63 studies were randomised controlled trials.

8 See Appendix V: Borawski, Trapl, Lovegreen, Colabianchi and Block, 2005; Clark, Trenholm, Devaney, Wheeler and Quay, 2007; Denny and Young, 2006; Kirby, Korpi, Barth and Cagampang, 1997; Rue and Weed, 2005; Trenholm *et al.*, 2007; Weed *et al.*, 1992; Weed *et al.*, 2008.

of seven reduced the number of sexual partners and six did not affect this outcome. In addition, none of the seven studies that measured impact on condom use found either a negative or positive impact, and none of the six studies that measured impact on contraceptive use found an impact. As new evidence becomes available, future versions of the guidance will seek to incorporate the new studies.

4.3 Impact on condom and contraceptive use

Forty per cent of programmes were found to increase condom use, while sixty per cent had no impact and none decreased condom use. Forty per cent of programmes also increased contraceptive use; 53 per cent had no impact, and 7 per cent (a single programme) reduced contraceptive use. Some studies assessed measures that included both the amount of sexual activity as well as condom or contraceptive use in the same measure. For example, some studies measured the frequency of sexual intercourse without condoms or the number of sexual partners with whom condoms were not always used. These measures were grouped and labelled 'sexual risk-taking'. Fifty-three per cent of the programmes decreased sexual risk-taking; 43 per cent had no impact and three per cent were found to increase it.

In summary, these studies demonstrate that more than a third of the programmes increased condom or contraceptive use, while more than half reduced sexual risk-taking, either among entire samples or in important sub-samples.

The positive results on the three measures of sexual activity, condom and contraceptive use and sexual risk-taking, are essentially the same when the studies are restricted to large studies with rigorous experimental designs. Thus, the evidence for the positive impacts upon behaviour is quite strong.

4.4 Impact on STI, pregnancy and birth rates

Because STI, pregnancy and childbearing occur less frequently than sexual activity, condom or contraceptive use, the distributions of the outcome measures of STI, pregnancy or childbearing require that considerably larger samples are needed to measure adequately the impact of programmes upon STI and pregnancy rates. Because many studies present results without having adequate statistical power, these results are not presented in Table 2.

While a small number of studies did evaluate programmes that had a significant reduction in STI and/or pregnancy rates, a greater number did not. Of the 18 studies that used biomarkers to measure impact on pregnancy or STI rates, 5 showed significant positive results and 13 did not.

4.5 Magnitude of impact

Even the effective programmes did not dramatically reduce risky sexual behaviour; their effects were more modest. The most effective programmes tended to lower risky sexual behaviour by, very roughly, one-fourth to one-third. For example, if 30 per cent of the control group had unprotected sex during a period of time, then only 20 per cent the intervention group did so, a reduction of 10 percentage points or a proportional reduction of one-third.

4.6 Breadth of behaviour results

Programmes that emphasised both abstinence and use of condoms and contraception were effective in changing behaviour when implemented in school, clinic and community settings and when addressing different groups of young people: e.g. both males and females, sexually inexperienced and experienced youth, and young people at lower and higher risk in disadvantaged and better-off communities.

Box 4. MEMA kwa Vijana (Good things for young people)

A particularly interesting study is that of the MEMA kwa Vijana programme (MKV) in a rural area of the United Republic of Tanzania. This study evaluated the impact of a multi-component programme comprised of a strong classroom-based curriculum, youth-friendly reproductive health services, community-based condom promotion and distribution for and by peers, together with a community sensitisation effort to create a supportive environment for the interventions.

A rigorous randomised trial found that the programme had some positive effects on reported sexual behaviour. For example, after a period of eight years the programme reduced the percentage of males who reported four or more lifetime sexual partners from 48 per cent to 40 per cent. It also increased the percentage of females who reported using a condom with a casual sexual partner from 31 per cent to 45 per cent.

However, the programme did not have any impact on HIV, other STI or pregnancy rates. There are at least three possible explanations for this. First, study participants' reports of sexual behaviour may have been biased and the programme may not have actually changed sexual behaviour. Second, the programme may have changed risk behaviours, but may not have changed the specific behaviours that have the greatest impact on pregnancy, STIs and HIV. Third, the programme may not have changed behaviours to such an extent as to make a difference in rates of pregnancy, STIs and HIV.

Whatever the explanation, the study is a caution that even a well-designed, curriculum-based programme implemented in concert with mutually reinforcing community-based elements still may not have a significant impact on pregnancy, STI or HIV rates.

Source: <http://www.memakwavijana.org>

4.7 Results of replication studies

Results from several replication studies in the United States are encouraging⁹. These studies demonstrate that when programmes found to be effective at changing behaviour in one study were replicated in similar settings, either by the same or different researchers, they consistently yielded positive results. Programmes were less likely to remain effective when their duration was shortened considerably, when they omitted activities that focused on increasing condom use, or when they were designed for and evaluated in community settings, but were subsequently implemented in classroom settings.

⁹ See Appendix V: Hubbard, Giese and Rainey, 1998; Jemmott, Jemmott, Braverman and Fong, 2005; St. Lawrence, Crosby, Brasfield and O'Bannon, 2002; St. Lawrence *et al.*, 1995; Zimmerman *et al.*, 2008; Zimmerman *et al.*, forthcoming.

4.8 Specific curriculum-based activities

Few studies have measured the impact of specific activities within curriculum-based programmes. However, two studies considered the impact of particular activities within larger, more comprehensive HIV prevention programmes, integrated within multiple courses in schools. The first study (Duflo *et al.*, 2006) found that, when young people observed a debate on whether school children should be taught how to use condoms and then wrote an essay about ways they could protect themselves from HIV, students were subsequently more likely to use condoms. The second study (Dupas, 2006) reported that the following activities all significantly decreased the rate of pregnancy among teenage girls with older men: providing HIV prevalence rates, disaggregated by age and sex; emphasising the risk of young women having sexual intercourse with older men (who are more likely to be HIV-positive); and showing a video about the danger of having sexual intercourse with older men. The biological marker of pregnancy among teenage girls with older men was perceived to be important both in itself and as an indicator of the amount of unprotected sexual intercourse between young women and older men.

4.9 Impact on cognitive factors

Nearly all sexuality education programmes that have been studied increased knowledge about different aspects of sexuality and risk of pregnancy or HIV and other STIs. This is important, because increasing knowledge is a primary role of schools. Programmes that were designed to reduce sexual risk and employed a logic model also strove to change other factors that affect sexual behaviour. Those programmes that were effective at either delaying or reducing sexual activity or increasing condom or contraceptive use typically focused on:

- Knowledge of sexual issues such as HIV, other STIs and pregnancy, including methods of prevention;
- Perceptions of risk e.g. of HIV, other STIs and of pregnancy;
- Personal values about sexual activity and abstinence;
- Attitudes about condoms and contraception;
- Perceptions of peer norms e.g. about sexual activity, condoms and contraception;

- Self-efficacy to refuse sexual intercourse and to use condoms;
- Intention to abstain from sexual intercourse or to restrict sexual activity or number of partners or to use condoms; and
- Communication with parents or other adults and potentially with sexual partners.

It should be emphasised that some studies demonstrated that particular programmes improved these factors (Kirby, Obasi & Laris, 2006; Kirby 2007). Other studies have demonstrated that these factors, in turn, have an impact on adolescent sexual decision-making (Blum & Mmari, 2006; Kirby & Lepore 2007). Thus, there is considerable evidence that effective programmes actually changed behaviour by having an impact on these factors, which then positively affected young people's sexual behaviour.

4.10 Summary of results

- Curriculum-based programmes implemented in schools or communities should be viewed as an important component that can often (but not necessarily always) reduce risky sexual behaviour. However, isolated from broader programmes in the community, these programmes do not always have a significant impact in terms of reducing HIV, STI or pregnancy rates.
- There is evidence that programmes did not have harmful effects: in particular, they did not hasten the initiation or increase sexual activity. The studies also demonstrate that it is possible, with the same programmes, to delay sexual intercourse and to increase the use of condoms or other forms of contraception. In other words, a dual emphasis on abstinence together with use of protection for those who are sexually active is not confusing to young people. Rather, it can be both realistic and effective.
- Nearly all studies of sexuality education programmes demonstrate increased knowledge.
- About two-thirds of them demonstrate positive results on behaviour among either the entire sample or an important sub-sample.
- More than one-fourth of the programmes improved two or more sexual behaviours among young people. Encouragingly, these programmes with positive behavioural results include those with strong evaluation designs and those that replicated similar programmes, with consistent results.
- Comparative analysis of effective and ineffective programmes provides strong evidence that those incorporating the characteristics of effective programmes (see section 5) can change the behaviours that put young people at risk of STIs and pregnancy.
- Even if sexuality education programmes improve knowledge, skills and intentions to avoid sexual risk or to use clinical services, reducing their risk may be challenging to young people if social norms do not support risk reduction and/or clinical services are not available.
- The sexuality education programmes studied had one big gap in common: none of them appeared to address the behaviours that cause significant HIV infection among adolescents in large parts of the world (i.e. Europe, Latin America and the Caribbean and Asia). Those behaviours are unsafe injecting drug use, unsafe sexual activity in the context of sex work and unprotected (mainly anal) sexual intercourse between men.



5. Characteristics of effective programmes

This section sets out the common characteristics of evaluated sexuality education programmes that have been found to be effective in terms of increasing knowledge, clarifying values and attitudes, increasing skills and impacting upon behaviour (Kirby, Roller and Wilson, 2007). For a summary of characteristics of effective programmes, see Table 3. These characteristics build upon those identified and verified through independent review (Kirby, 2005).

5.1 Characteristics of the process of developing the curriculum

1. Involve experts in research on human sexuality, behaviour change and related pedagogical theory in the development of curricula

Just like mathematics, science, languages and other fields, human sexuality is an established field based on an extensive body of research and knowledge. Thus, people familiar with this research and knowledge should be involved in developing or selecting and adapting curricula. In addition, if programmes are designed to reduce sexual risk behaviour, then the curriculum developers must be knowledgeable about what risky behaviours young people are actually engaging in at different ages, what environmental and cognitive factors affect those behaviours, and how best to address those factors.

To create programmes that reduce sexual risk behaviour, curriculum developers must use theory and research about the factors affecting sexual behaviour to identify the factors the programme will address. Then, the curriculum developers must use effective instructional methods to address each of those factors. This requires them to be proficient in theory, psychosocial factors affecting sexual behaviour and effective teaching methods for changing those factors. And, of course,

they need knowledge about other sexuality education programmes that changed behaviour, especially those that addressed similar communities and young people.

2. Assess the reproductive health needs and behaviours of young people in order to inform the development of the logic model

While there is considerable commonality among young people in terms of their needs regarding sexuality, there are also many differences across communities, settings and age groups in their knowledge, their beliefs, their attitudes and skills, and their reasons for failing to avoid unwanted, unintended and unprotected sexual intercourse. Effective sexuality education programmes should strive to identify and address these reasons.

It is also important to build upon young people's existing knowledge, positive attitudes and skills. Thus, effective programmes should build on these assets as well as address deficits.

The needs and assets of young people can be assessed through focus groups with young people and interviews with professionals who work with them as well as reviews of research data from the target group or similar populations.

3. Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors

A logic model is a process or tool used by programme developers to plan and design a programme. Most effective programmes that changed behaviour, and especially those that reduced pregnancy or STI rates, used a clear four-step process for creating the curriculum: 1) they identified the health goals (e.g. reducing unintended pregnancy or HIV and other STIs); 2) they identified the specific behaviours that affected pregnancy and HIV/STI rates and that could be changed; 3) they identified the cognitive (or psychosocial) factors that affect those behaviours (e.g. knowledge, attitudes, norms, skills, etc.); and 4) they created multiple activities to change each factor. This logic model was the theory or basis for their effective programmes.

4. Design activities that are sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies)

This is an important step for all programmes. While this characteristic may seem obvious, there are numerous examples of people who developed curricula that could not be fully implemented because they were not sensitive to community values and resources; consequently, these programmes were not fully implemented or were prematurely terminated.

5. Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs

Pilot-testing the programme with individuals representing the target population allows for adjustments to be made to any programme component before formal implementation. This gives programme developers an opportunity to fine-tune the programme as well as to discover important and needed changes. For example, they may change a scenario or wording in a role-play to make it more appropriate, familiar or understandable for programme participants. During pilot-testing, conditions should be as close as possible to those prevailing in the intended implementation setting. The entire curriculum should be pilot-tested and practical feedback from participants should be obtained, especially on what did and did not work and on ways to make weak elements stronger and more effective.

5.2 Characteristics of the curriculum itself

6. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy

Effective curricula are focused curricula. Specifically in relation to sexuality education, this means focusing upon young people's susceptibility (for example, to HIV, other STIs or pregnancy) and the negative consequences of these occurrences. Effective curricula give clear messages about these goals: e.g. if young people have unprotected sexual intercourse on a regular basis they are potentially at risk of HIV, other STIs or of becoming



pregnant (or of causing a pregnancy), and that there are negative consequences associated with these occurrences. In the process of doing this, effective curricula motivate young people to want to avoid STIs and unintended pregnancy.

7. Focus narrowly on specific risky sexual and protective behaviours leading directly to these health goals

Young people can avoid the risks of acquiring HIV or other STIs, by avoiding sexual intercourse. If they do have sexual intercourse and wish to reduce the risks of HIV, STIs or pregnancy, they should use condoms correctly and consistently, reduce the number of sexual partners, avoid concurrent sexual partnerships, be in mutually exclusive sexual relationships, be tested (and treated as necessary) for STIs and vaccinated against those STIs for which vaccinations exist (i.e. Human Papilloma Virus (HPV) and Hepatitis B). In high HIV prevalence settings in sub-Saharan Africa, WHO recommends male circumcision as an additional measure to reduce the risk of acquiring HIV through unprotected vaginal intercourse (WHO and UNAIDS, 2009). To reduce the risk of pregnancy, young people should abstain from sex or else use an effective method of contraception.

Effective curricula focus on particular behaviours in a variety of ways. They talk about delaying age of first sex, informed decision-making about initiating sex, and perceptions and peer pressures around sexual activity. They also talk about sexual intercourse, having fewer partners, avoiding concurrent partnerships, and increasing condom use and contraceptive use when sexually active. It is necessary that this information is conveyed in ways that are clearly understood, in explicit terms which are culturally relevant and age-appropriate. For example, they have identified the pressures to have sexual intercourse facing young

people and have suggested ways of responding to this. Curricula have identified specific situations that could lead to unwanted or unprotected sexual intercourse and have explored coping strategies. During sessions, young people learn how to correctly use condoms, and are introduced to other contraceptive methods. They also learn ways of overcoming barriers to obtaining or using these, for example, identifying specific places where young people can obtain low-cost and confidential services (including contraceptives, HIV counselling, testing and treatment for STIs).

A few effective programmes have established direct and close linkages with nearby reproductive health services. These have facilitated the use of contraception and STI testing, for example.

8. Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them

It is important, ideally with the input of young people themselves, to identify the specific situations in which young people are likely to be most pressured into sexual activity and to rehearse strategies for avoiding and getting out of them. In those communities where drug and/or alcohol use is associated with unprotected sexual intercourse, it is important also to address the impact of drugs and alcohol on sexual behaviour. It is also important to address perpetration of sexual violence and the use of coercion to obtain sexual favours.

9. Give clear messages about behaviours to reduce risk of STIs or pregnancy

Providing clear messages about risk and protective behaviours appears to be one of the most important characteristics of effective programmes. Nearly all effective programmes repeatedly, and in a variety of ways, reinforce clear and consistent messages about protective behaviours. In fact, most activities in the curriculum are designed to change behaviours so that they will be consistent with the message. Given that the majority of effective programmes are designed to reduce HIV and other STIs, the most common messages disseminated are that young people should either avoid sexual intercourse or else use a condom every time they have sexual intercourse with every partner. Some effective programmes also emphasise being faithful and avoiding multiple or concurrent sexual partners. Culturally-specific messages in some countries also emphasise the dangers

of 'sugar daddies' (older men who offer gifts or treats, often implicitly in return for sexual intercourse). Other programmes encourage testing and treatment for STIs, including HIV. Programmes concerned with pregnancy prevention tend to emphasise that young people should abstain, delay sexual relations and/or use contraception every time they have sex. Some programmes identify and appeal to important community values e.g. 'be proud', 'be responsible', or 'respect yourself'. When programmes do appeal to these values, they make very clear the specific sexual and protective behaviours that are consistent with these values.

10. Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, social norms, attitudes and skills)

Risk and protective factors have an important impact on young people's decision-making about sexual behaviour. These include cognitive factors, such as knowledge, values, perception of peer norms, attitudes, skills and intentions, as well as external factors, such as access to adolescent-friendly health and social support services. Curriculum-based programmes, especially those in schools, typically focus primarily on internal cognitive factors, but they also describe how to access reproductive health services. The knowledge, values, norms, etc., that are emphasised in sexuality education also need to be supported by social norms and multiple endeavours promoted by trusted adults who both model and provide reinforcement.

Gender social norms and gender inequality affect the experience of sexuality, sexual behaviour and sexual and reproductive health. Gender discrimination is common and young women often have less power or control in their relationships, making them more vulnerable, in some settings, to abuse and exploitation by boys and men, particularly older men. Men may also feel pressure from their peers to fulfil male sexual stereotypes and engage in harmful behaviours.

In order to be effective at reducing sexual risk behaviour, curricula need to examine critically and address these gender inequalities and stereotypes. For example, they need to discuss the specific circumstances faced by young women and young men and provide effective skills and methods of avoiding unwanted or unprotected sexual activity in those situations. Such activities should set out to address gender inequality, social norms and

stereotypes, and should in no way promote harmful gender stereotypes.

11. Employ participatory teaching methods that actively involve students and help them internalise and integrate information

A broad range of participatory teaching methods have been used in the implementation of effective curricula. Typically, these promote the active involvement of students in a task or activity, conducted in the classroom or community, followed by a period of discussion or reflection in order to draw out specific learning. Methods need to be matched to specific learning objectives.

12. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors

Multiple activities are usually necessary to address each risk and protective factor; thus, many activities are needed. This is one reason why successful programmes usually last for at least 12 to 20 sessions.

In addition, the activities need to include instructional strategies that are designed to change the associated risk or protective factors, e.g. role-playing to increase self-efficacy and skills to refuse unwanted sexual activity or avoid possible situations that might lead to unwanted sexual activity.

13. Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection

Information within a curriculum should be evidence-informed, scientifically accurate and balanced, neither exaggerating nor understating the risks or effectiveness of condoms or other forms of contraception.

14. Address perceptions of risk (especially susceptibility).

Effective curricula focus on both the susceptibility to and the severity of HIV, other STIs and unintended pregnancy. Personal testimony, simulations and role-playing have all been found to be useful adjuncts to statistical and other factual information in exploring the concepts of risk, susceptibility and severity.

15. Address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners.

Personal values have significant impact on sexual behaviour. Effective programmes have promoted the following values: abstinence; non-sexual ways of demonstrating affection; and being in long-term, loving, mutually faithful sexual relationships. These values have been explored through surveys, role-plays and homework assignments, including communication with parents.

16. Address individual attitudes and peer norms concerning condoms and contraception

Similarly, personal values and attitudes also affect condom and contraceptive use. Thus, effective programmes have presented clear messages about these, together with accurate information about their effectiveness. They have also helped students to explore their attitudes towards condoms and contraception and have identified perceived barriers to their use, e.g. difficulties obtaining and carrying condoms, possible embarrassment when asking one's partner to use a condom, or any difficulties actually using a condom, and then have discussed methods of overcoming these barriers.

17. Address both skills and self-efficacy to use those skills

In order to avoid unwanted or unprotected sexual intercourse, young people need the following skills: the ability to refuse unwanted, unintended or unprotected sexual intercourse; the ability to insist on using condoms or contraception; and the ability to obtain and use these correctly. The first two require communication with a partner. Role playing, representing a range of typical situations, is commonly used to teach these skills with elements of each skill identified before rehearsal in progressively complex scenarios. Condom use and acquisition skills are typically acquired through demonstration and visits to places where they are available.

18. Cover topics in a logical sequence

Topics should be taught in a logical sequence. Many effective curricula focus first upon strengthening motivation to avoid STI/HIV infection and pregnancy by emphasising susceptibility to and severity of these, before going on to address the specific knowledge, attitudes and skills required to avoid them.

Table 3. Summary of characteristics of effective programmes

Characteristics
1. Involve experts in research on human sexuality, behaviour change and related pedagogical theory in the development of curricula.
2. Assess the reproductive health needs and behaviours of young people in order to inform the development of the logic model.
3. Use a logic model approach that specifies the health goals, the types of behaviour affecting those goals, the risk and protective factors affecting those types of behaviour, and activities to change those risk and protective factors.
4. Design activities that are sensitive to community values and consistent with available resources (e.g. staff time, staff skills, facility space and supplies).
5. Pilot-test the programme and obtain on-going feedback from the learners about how the programme is meeting their needs.
6. Focus on clear goals in determining the curriculum content, approach and activities. These goals should include the prevention of HIV, other STIs and/or unintended pregnancy.
7. Focus narrowly on specific risky sexual and protective behaviours leading directly to these health goals.
8. Address specific situations that might lead to unwanted or unprotected sexual intercourse and how to avoid these and how to get out of them.
9. Give clear messages about behaviours to reduce risk of STIs or pregnancy.
10. Focus on specific risk and protective factors that affect particular sexual behaviours and that are amenable to change by the curriculum-based programme (e.g. knowledge, values, social norms, attitudes and skills).
11. Employ participatory teaching methods that actively involve students and help them internalise and integrate information.
12. Implement multiple, educationally sound activities designed to change each of the targeted risk and protective factors.
13. Provide scientifically accurate information about the risks of having unprotected sexual intercourse and the effectiveness of different methods of protection.
14. Address perceptions of risk (especially susceptibility).
15. Address personal values and perceptions of family and peer norms about engaging in sexual activity and/or having multiple partners.
16. Address individual attitudes and peer norms toward condoms and contraception.
17. Address both skills and self-efficacy to use those skills.
18. Cover topics in a logical sequence.



to have enduring behavioural effects at two or more years follow-up have either involved the provision of sequential sessions over the course of two or three years, or else they are programmes in which most sessions have been provided during the first year and followed up with 'booster' sessions delivered months, or even years, later. This enables more sessions to be provided than might otherwise have been possible. It also makes it possible to reinforce important concepts over the

6. Good practice in educational institutions

This section sets out common recommendations, based on identified good practice in educational institutions (Kirby, 2009; Kirby, 2005).

1. Implement programmes that include at least twelve or more sessions

In order to address the needs of young people for information about sexuality, multiple topics need to be covered. In order to reduce sexual risk-taking among young people, both risk and protective factors that affect decision-making need to be addressed. Both of these approaches take time: nearly all the programmes in schools found to have a positive effect upon long-term behaviour have included 12 or more sessions, and sometimes 30 or more sessions, that last roughly 50 minutes or so.

2. Include sequential sessions over several years

To maximise learning, different topics need to be covered in an age-appropriate manner over several years. When giving young people clear messages about behaviour, it is also important to reinforce those messages over time. Most of the programmes found

to have enduring behavioural effects at two or more years follow-up have either involved the provision of sequential sessions over the course of two or three years, or else they are programmes in which most sessions have been provided during the first year and followed up with 'booster' sessions delivered months, or even years, later. This enables more sessions to be provided than might otherwise have been possible. It also makes it possible to reinforce important concepts over the course of several years. A few of these programmes have also implemented school- or community-wide activities over subsequent years. Thus, students could be exposed to the curriculum within the classroom for two or three years and their learning could then be reinforced through school or community-wide components in subsequent years.

3. Select capable and motivated educators to implement the curriculum.

The qualities of the educators can have a huge impact on the effectiveness of the curriculum. Those who deliver curricula should be selected through a transparent process that identifies relevant and desirable characteristics. These include: an interest in teaching the curriculum; personal comfort discussing sexuality; ability to communicate with students; and skill in the use of participatory learning methodologies. If they lack knowledge about the topic, then training should be available (see next characteristic). If it is mostly men who are likely to be selected as educators, then strategies can be implemented to recruit more women, and vice-versa.

Educators may be the regular classroom teachers (especially health education or life skills education teachers) or specially trained teachers who only teach sexuality education and move from classroom to classroom covering all of the relevant grades in the schools. The advantages of general classroom teachers include the following: they are part of the school structure; they may be known and trusted by the community; they have already established relationships with learners; and they can integrate sexuality education

messages into different subjects. The advantages of using specialist sexuality education educators include: they can be specially trained to cover this sensitive topic and to implement participatory activities; they can be provided with regularly updated information; and they can be linked to community-based reproductive health services. Studies have demonstrated that programmes can be effectively delivered by both groups of educators (Kirby, Obasi & Laris, 2006; Kirby, 2007).

Debate continues regarding the relative effectiveness of peer-led versus adult-led delivery of sexuality education curricula. There is stronger evidence that adult-led (as compared to peer-led) programmes demonstrate positive effects on behaviour. However, this reflects the larger number of studies that have focused on adult-led programmes. Three randomised trials and a formal meta-analysis comparing the respective effectiveness of adult- and peer-led programmes have been inconclusive (Stephenson et al., 2004; Jemmott et al., 2004; Kirby et al., 1997). None have found strong evidence that adult-led programmes are more or less effective than peer-led programmes.

4. Provide quality training to educators

Specialised training is important for teachers because delivering sexuality education often involves new concepts and new learning methods. This training should have clear goals and objectives, should teach and provide practice in participatory learning methods, should provide a good balance between learning content and skills, should be based on the curriculum that is to be implemented, and should provide opportunities to

rehearse key lessons in the curriculum. All of this can increase the confidence and capability of the educators. The training should help educators distinguish between their personal values and the health needs of learners. It should encourage educators to teach the curriculum in full, not selectively. It should address challenges that will occur in some communities e.g. very large class sizes and priority given to teaching examinable subjects. It should last long enough to cover the most important knowledge content and skills and to allow teachers time to personalise the training and raise questions and issues. If possible and appropriate, it should address teachers' own concerns about their sexual health and HIV status. Finally, it should be taught by experienced and knowledgeable trainers. At the end of the training, participants' feedback on the training should be solicited.

5. Provide on-going management, supervision and oversight

Because sexuality education is not well established in many schools, school managers should provide encouragement, guidance and support to teachers involved in delivering it. Supervisors should make sure the curriculum is being implemented as planned, that all parts are fully implemented (not just the biological parts that often may be part of examinations), and that teachers have access to support in responding to new and challenging situations as these arise in the course of their work. Supervisors should also keep abreast of important developments in the field of sexuality education so that any necessary adaptations can be made to the school's programme.

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Appendices

Appendix I

International conventions and agreements relating to sexuality education

United Nations Committee on the Rights of the Child. CRC/GC/2003/4, 1 July 2003. General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child (CRC)¹⁰

“The Committee calls upon States parties to develop and implement, in a manner consistent with adolescents’ evolving capacities, legislation, policies and programmes to promote the health and development of adolescents by (...) (b) providing adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behaviour and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent’s rights (art. 27 (3));” (CRC/GC/2003/4, para. 16)

“Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity.” (CRC/GC/2003/4, para 26)

United Nations Committee on Economic, Social and Cultural Rights. E/C.12/2000/4, 11 August 2000. Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights. General Comment 14¹¹

“The Committee interprets the right to health, as defined in article 12.1, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as [...] access to health-related education and information, including on sexual and reproductive health.” (E/C.12/2000/4, para. 11)

“By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health(...)” (E/C.12/2000/4, para. 18)

“To eliminate discrimination against women, there is a need to develop and implement a comprehensive national strategy for promoting women’s right to health throughout their life span. Such a strategy should include interventions aimed at the prevention and treatment of diseases affecting women, as well as policies to provide access to a full range of high quality and affordable health care, including sexual and reproductive services. A major goal should be

10 UN. 2003. United Nations Committee on the Rights of the Child. General Comment 4: Adolescent health and development in the context of the Convention on the Rights of the Child (CRC). CRC/GC/2003/4. New York: UN. See also: UN. 1989. United Nations Convention on the Rights of the Child. New York: UN.

11 UN. 2000. United Nations Committee on Economic, Social and Cultural Rights. Substantive issues arising in the implementation of the international covenant on economic, social and cultural rights. General Comment No. 14. E/C.12/2000/4. New York: UN.

reducing women's health risks, particularly lowering rates of maternal mortality and protecting women from domestic violence. The realization of women's right to health requires the removal of all barriers interfering with access to health services, education and information, including in the area of sexual and reproductive health. It is also important to undertake preventive, promotive and remedial action to shield women from the impact of harmful traditional cultural practices and norms that deny them their full reproductive rights." (E/C.12/2000/4, para. 21)

United Nations Convention on the Rights of Persons with Disabilities. A/61/611, 6 December, 2006. Article 25 – Health¹²

"States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation. In particular, States Parties shall:

- (a) Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes..."

International Conference on Population and Development (ICPD) Programme of Action (POA)¹³

"All countries should strive to make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages as soon as possible and no later than the year 2015. Reproductive health care in the context of primary health care should, inter alia, include: family-planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and appropriate treatment of infertility; abortion as specified in paragraph 8.25, including prevention of abortion and the management of the consequences of abortion; treatment of reproductive tract infections; sexually transmitted

diseases and other reproductive health conditions; and information, education and counselling, as appropriate, on human sexuality, reproductive health and responsible parenthood." (ICPD POA, para. 7.6)

"Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning and in domestic and child-rearing responsibilities and to accept the major responsibility for the prevention of sexually transmitted diseases. Programmes must reach men in their workplaces, at home and where they gather for recreation. Boys and adolescents, with the support and guidance of their parents, and in line with the Convention on the Rights of the Child, should also be reached through schools, youth organizations and wherever they congregate. Voluntary and appropriate male methods for contraception, as well as for the prevention of sexually transmitted diseases, including AIDS, should be promoted and made accessible with adequate information and counselling." (ICPD POA, para. 7.9)

"The objectives are: (a) To promote adequate development of responsible sexuality, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals; (b) To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities." (ICPD POA, para. 7.36)

"Support should be given to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress responsibility of males for their own sexual health and fertility and that help them exercise those responsibilities. Educational efforts should begin within the family unit, in the community and in the schools at an appropriate age, but must also reach adults, in particular men, through non-formal education and a variety of community-based efforts. (ICPD POA, para. 7.37)

"In the light of the urgent need to prevent unwanted pregnancies, the rapid spread of AIDS and other sexually transmitted diseases, and the prevalence of sexual abuse and violence, Governments should base national policies on a better understanding of the need for responsible human sexuality and the realities of current sexual behaviour." (ICPD POA, para. 7.38)

12 UN. 2006. United Nations Convention on the Rights of Persons with Disabilities. A/61/611. New York: UN.

13 UN. 1994. International Conference on Population and Development. Programme of Action. New York: UN.

“Recognizing the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capacities of the adolescent, appropriate direction and guidance in sexual and reproductive matters, countries must ensure that the programmes and attitudes of health-care providers do not restrict the access of adolescents to appropriate services and the information they need, including on sexually transmitted diseases and sexual abuse. In doing so, and in order to, inter alia, address sexual abuse, these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs. In this context, countries should, where appropriate, remove legal, regulatory and social barriers to reproductive health information and care for adolescents.” (ICPD POA, para. 7.45)

“Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care and greatly reduce the number of adolescent pregnancies.” (ICPD POA, 7.46)

“Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents will require special family-planning information, counselling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities.” (ICPD POA, para. 7.47)

“Programmes should involve and train all who are in a position to provide guidance to adolescents concerning responsible sexual and reproductive behaviour, particularly parents and families, and also communities, religious institutions, schools, the mass media and peer groups. Governments and non-governmental

organizations should promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behaviour and reproductive health.” (ICPD POA, 7.48)

United Nations. A/S-21/5/Add.1, 1 July 1999. Overall review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development (ICPD + 5)¹⁴

“Governments, in collaboration with civil society, including non-governmental organizations, donors and the United Nations system, should: (a) Give high priority to reproductive and sexual health in the broader context of health-sector reform, including strengthening basic health systems, from which people living in poverty in particular can benefit; (b) Ensure that policies, strategic plans, and all aspects of the implementation of reproductive and sexual health services respect all human rights, including the right to development, and that such services meet health needs over the life cycle, including the needs of adolescents, address inequities and inequalities due to poverty, gender and other factors and ensure equity of access to information and services; (c) Engage all relevant sectors, including non-governmental organizations, especially women’s and youth organizations and professional associations, through ongoing participatory processes in the design, implementation, quality assurance, monitoring and evaluation of policies and programmes, in ensuring that sexual and reproductive health information and services meet people’s needs and respect their human rights, including their right to access to good-quality services; Develop comprehensive and accessible health services and programmes, including sexual and reproductive health, for indigenous communities with their full participation that respond to the needs and reflect the rights of indigenous people; [...]” (A/S-21/5/Add.1, para. 52(a)-(d))

United Nations Fourth World Conference on Women (FWCW) Platform for Action (PFA)¹⁵

“The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and

14 UN. 1999. Overall Review and Appraisal of the Implementation of the Programme of Action of the International Conference on Population and Development. A/S-21/5/Add.1. New York: UN.

15 UN. 1995. United Nations Fourth World Conference on Women. Platform for Action. New York: UN.

reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.” (FWCW PFA, para. 96)

“Actions to be taken by Governments, international bodies including relevant United Nations organizations, bilateral and multilateral donors and non-governmental organizations [...] (k) Give full attention to the promotion of mutually respectful and equitable gender relations and, in particular, to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality;” (FWCW PFA, para. 108(k) and A/S-21/5/Add.1, para. 71(j))

“Actions to be taken by Governments, in cooperation with non-governmental organizations, the mass media, the private sector and relevant international organizations, including United Nations bodies, as appropriate [...] (g) Recognize the specific needs of adolescents and implement specific appropriate programmes, such as education and information on sexual and reproductive health issues and on sexually transmitted diseases, including HIV/AIDS, taking into account the rights of the child and the responsibilities, rights and duties of parents as stated in paragraph 107 (e) above;” (FWCW PFA, para. 107(g))

United Nations. A/RES/S-26/2, 2 August 2001. General Assembly Special Session on HIV/AIDS, Declaration of Commitment on HIV/AIDS¹⁶

“We, the Heads of State and Government and Representatives of Heads of State and Government, solemnly declare our commitment to address the HIV/AIDS crisis by taking action as follows [...] By 2003, develop and/or strengthen strategies, policies and programmes, which recognize the importance of the family in reducing vulnerability, inter alia, in educating and guiding children and take account of cultural, religious and ethical factors, to reduce the vulnerability of children and young people by: ensuring access of both girls and boys to primary and secondary education, including on HIV/AIDS in curricula for adolescents; ensuring safe and secure environments, especially for young girls; expanding good quality youth-friendly information and sexual health education and counselling service; strengthening reproductive

and sexual health programmes; and involving families and young people in planning, implementing and evaluating HIV/AIDS prevention and care programmes, to the extent possible;” (para. 63)

More general references may also include:

- The 2000 Education for All (EFA) Dakar Framework for Action¹⁷ stresses in one of its six goals that youth-friendly programmes must be made available to provide the information, skills, counselling and services needed to protect young people from the risks and threats that limit their learning opportunities and challenge education systems, such as school-age pregnancy and HIV and AIDS.
- EDUCAIDS¹⁸, the UNAIDS initiative for a comprehensive education sector response to HIV and AIDS that is led by UNESCO, recommends that HIV and AIDS curricula in schools “begin early, before the onset of sexual activity”, “build knowledge and skills to adopt protective behaviours and reduce vulnerability”, and “address stigma and discrimination, gender inequality and other structural drivers of the epidemic”.
- The World Health Organization¹⁹ (WHO, 2004) concludes that it is critical that sexuality education be started early, particularly in developing countries, because girls in the first classes of secondary school face the greatest risk of the consequences of sexual activity, and beginning sexuality education in primary school also reaches students who are unable to attend secondary school. Guidelines from the WHO Regional Office for Europe call on Member States to ensure that education on sexuality and reproduction is included in all secondary school curricula and is comprehensive.²⁰
- UNAIDS²¹ has concluded that the most effective approaches to sexuality education begin with educating young people before the onset of sexual activity.²² UNAIDS recommends that HIV prevention programmes: be comprehensive, high quality and evidence-informed; promote gender equality and address gender norms and relations; and include accurate and explicit information about safer sex, including correct and consistent male and female condom use.

16 UN. 2001. United Nations General Assembly Special Session on HIV/AIDS. Declaration of Commitment on HIV/AIDS. . A/RES/S-26/2. New York: UN.

17 UNESCO. 2000. Dakar Framework for Action: Education for All. Meeting Our Collective Commitments. Paris, UNESCO.

18 UNESCO. 2008. EDUCAIDS Framework for Action. Paris: UNESCO.

19 WHO. 2004. Adolescent Pregnancy Report. Geneva: WHO

20 WHO. 2001. WHO Regional Strategy on Sexual and Reproductive Health. Copenhagen: WHO, Regional Office for Europe.

21 UNAIDS. 2005. Intensifying HIV Prevention, supra note 26, at 33. Geneva: UNAIDS.

22 UNAIDS. 1997. Impact of HIV and Sexual Health on the Sexual Behaviour of Young People: A Review Update 27. Geneva: UNAIDS.

Appendix II

Criteria for selection of evaluation studies

To be included in this review of sex, relationships and HIV/STI education programmes, each study had to meet the following criteria:

1. The evaluated programme had to:
 - (a) be an STI, HIV, sex, or relationship education programme which is curriculum-based and group-based (as opposed to an intervention involving only spontaneous discussion, only one-on-one interaction, or only broad school, community, or media awareness activities) and curricula had to encourage more than abstinence as methods of protection against pregnancy and STIs.
 - (b) focus primarily on sexual behaviour (as opposed to covering a variety of risk behaviours such as drug use, alcohol use, and violence in addition to sexual behaviour).
 - (c) focus on adolescents up through age 24 outside of the US or up through age 18 in the US.
 - (d) be implemented anywhere in the world.
2. The research methods had to:
 - (a) include a reasonably strong experimental or quasi-experimental design with well-matched intervention and comparison groups and both pre-test and post-test data collection.
 - (b) have a sample size of at least 100.
 - (c) measure programme impact on one or more of the following sexual behaviours: initiation of sex, frequency of sex, number of sexual partners, use of condoms, use of contraception more generally, composite measures of sexual risk (e.g., frequency of unprotected sex), STI rates, pregnancy rates, and birth rates.
 - (d) measure impact on those behaviours that can change quickly (i.e., frequency of sex, number of sexual partners, use of condoms, use of contraception, or sexual risk taking) for at least 3 months or measure impact on those behaviours or outcomes that change less quickly (i.e., initiation of sex, pregnancy rates, or STI rates) for at least 6 months.
3. The study had to be completed or published in 1990 or thereafter. In an effort to be as inclusive as possible, the criteria did not require that studies had been published in peer-reviewed journals.

Review methods

In order to identify and retrieve as many of the studies throughout the entire world as possible, several tasks were completed, several of them on an ongoing basis over two to three years. More specifically, we:

1. Reviewed multiple computerised databases for studies meeting the criteria (i.e., PubMed, PsychInfo, Popline, Sociological Abstracts, Psychological Abstracts, Bireme, Dissertation Abstracts, ERIC, CHID, and Biologic Abstracts).
2. Reviewed the results of previous searches completed by Education, Training and Research Associates and identified those studies meeting the criteria specified above.
3. Reviewed the studies already summarised in previous reviews completed by others.
4. Contacted 32 researchers who have conducted research in this field asked them to review all the studies previously found and to suggest and provide any new studies.
5. Attended professional meetings, scanned abstracts, spoke with authors, and obtained studies whenever possible.
6. Scanned each issue of 12 journals in which relevant studies might appear.

This comprehensive combination of methods identified 109 studies meeting the criteria above. These studies evaluated 85 programmes (some programmes had multiple articles). All of these were obtained, coded and summarised in Table 2 section 4.

Appendix III

People contacted and key informant details

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Appendix IV

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Appendix V

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